## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)  NAME OF PROVIDER OR SUPPLIER:  ST. MONICA CENTER FOR REHABI HEALTHCARE		(XI) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBER 395558 BILITATION &	` ′		IP CODE:	(X3) DATE SURVEY COMPLETED: 03/30/2023	
STATE LICENSE NUMBER: 232602  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES)			FICIENCY	ID	DDOVIDED'S DI AN QE CODDE	CTION (EACH	(X5)
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F 0000	Based on an Abbreviated Survey in response to a complaint completed on March 30, 2023, at St Monica Center for Rehabilitation and Healthcare, identified no deficient practice under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process.		F 0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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## **Certified End Page**

## ST. MONICA CENTER FOR REHABILITATION & HEALTHCARE

STATE LICENSE NUMBER: 232602 SURVEY EXIT DATE: 03/30/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi

Deputy Secretary for Quality Assurance

fearre Janie

Debra L. Bogu MD

Debra L. Bogen, MD, FAAP Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

## **PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY